TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Ennis Orthopedics

**Respondent Name**
LM Insurance Corp

**MFDR Tracking Number**
M4-17-2588-01

**Carrier's Austin Representative**
Box Number 01

**MFDR Date Received**
May 2, 2017

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** No position statement submitted.

**Amount in Dispute:** $1,700.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The bill and documentation attached to the medical dispute have been re-reviewed and our position remains unchanged. Our rationale is as follows: Denied 27428 as Documentation does not support level of service billed. (X901). CPT 27428 is Ligamentous reconstruction (augmentation), knee; intra-articular (open). Documented procedure is arthroscopic ACL [anterior cruciate ligament] augmentation with Arthrocare wand [tightening of ligament using thermal treatment] Provider billed a CPT for an open procedure and the operative report supports arthroscopic ACL augmentation."

**Response Submitted by:** Liberty Mutual Insurance

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| January 3, 2017 | 27428 | $1,700.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement policies for professional medical

services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X901 – Documentation does not support level of service billed
   - U301 – This item has been reviewed on a previously submitted bill, or is currently in process. Notification of decision has been previously provided or will be issued upon completion of our review
   - 193 – The charge for this procedure exceeds the fee schedule allowance

**Issues**

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

**Findings**

1. The requestor is seeking reimbursement for surgical procedure code 27428 – "Ligamentous reconstruction (augmentation), knee; intra-articular (open)" rendered on January 3, 2017.

   The insurance carrier denied disputed services with claim adjustment reason code X901 – "Documentation does not support level of service billed."

   28 Texas Administrative Code §134.203 (b) states in pertinent part,

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   >
   > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

   The lay description of code 27428 is described as, "In 27428, the physician makes an incision to access the knee joint and the ligaments within the joint. The injured ligament is identified and reattached at its torn end.

   Review of the submitted document "Operative Report" finds the following, "Standard medial and lateral portals were utilized to visualize to visualize [sic] the joint… Once this tear was identified, intraoperative examination did reveal slight anterior laxity. The low-voltage setting on ArthroCare wand was used to perform an augmentation of this ligament. Care was taken not to overtighten the ligament and once the augmentation was complete, there were no further visible tears."

   Based on review of the above, the insurance carrier's denial reason X901 – "Documentation does not support level of service billed" is supported. Additional reimbursement cannot be recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | May 24, 2017<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.